The POLICY Project

Case Study of Contraceptive Self-reliance Efforts in Turkey: Prospects and Lessons Learned

November 1999

The Futures Group International
in collaboration with:
Research Triangle Institute (RTI)
The Centre for Development and
Population Activities (CEDPA)

POLICY is a five-year project funded by the U.S. Agency for International Development under Contract No. CCP-C-00-95-00023-04, beginning September 1, 1995. The project is implemented by The Futures Group International in collaboration with Research Triangle Institute (RTI) and The Centre for Development and Population Activities (CEDPA).

For more information, please contact:
Director, The POLICY Project
The Futures Group International
1050 17th Street, NW, Suite 1000
Washington, DC 20036
Telephone: (202) 775-9680
Facsimile: (202) 775-9694
E-mail: policyinfo@tfgi.com
Internet: http://www.tfgi.com

Case Study of Contraceptive Self-reliance Efforts in Turkey: Prospects and Lessons Learned

The POLICY Project

November 1999

TABLE OF CONTENTS

TABLES AND FIGURES

ABBREVIATIONS

CTO	Cognizant Technical Officer
DAFA	Department of Administration and Financial Affairs
DHS	Demographic and Health Survey
GD MCH/FP	General Directorate of Maternal and Child Health and Family Planning
GDP	Gross Domestic Product
GOT	Government of Turkey
HSAF	Health and Social Aid Foundation
KIDOG	Turkish Advocacy for Women's Network
IUD	Intra-uterine device
MOF	Ministry of Finance
MOH	Ministry of Health
NGO	Nongovernmental organization
OC	Oral contraceptive
SPO	State Planning Organization
SSK	Sosyal Sigortalar Kuruma
USAID	United States Agency for International Development

ACKNOWLEDGMENTS

This case study report represents the combined efforts of a large number of persons. POLICY wishes to thank the 29 case study respondents in Turkey who generously shared their time to discuss the long and challenging process of coping with the phase-out of USAID's assistance last area of development assistance to their country. (A list of respondents is provided in Appendix B to this report.) The depth of their understanding of the issues, as well as the honesty and openness of these individuals during the case study interviews, is but a small testament to the strength of the commitment to achieve self-reliance in the national family planning program. This case study benefited immensely from their reflections and perceptions. POLICY also wishes to thank Dr. Pinar Senlet, Population Advisor at the U.S. Embassy in Ankara, and Ms. Elizabeth Schoenecker, USAID's CTO for the POLICY Project for their encouragement and support throughout this case study process. Moral and technical support from Ms. Maureen E. Clyde, POLICY's Regional Director for the Europe and Eurasia region, was also critical to completion of this case study. Her contributions improved the study from the conceptualization stage to the report review stage.

Active partnership with POLICY's Ankara-based team was instrumental in completing this case study. Dr. Zerrin Baser, Country Program Manager, Dr. Fahreddin Tatar, Senior Policy Analyst, and Ms. Sema Hosta, Participation Coordinator, provided important input into the conceptualization of the study and development of the interview instruments. They were critical to the long and arduous interview effort, which had to be organized on a tight time schedule around an important holiday period. Their review of the case study report draft helped to refine the analysis, a contribution that provides an important check on the qualitative and often subjective nature of case study data analysis.

Every effort has been made to be true to the perspectives and opinions expressed by case study respondents and to POLICY colleagues who participated in conducting this case study. Final responsibility, however, for the conclusions and opinions expressed in this report lie solely with the principal author, Dr. Jeffrey Sine.

EXECUTIVE SUMMARY

Since the inception in the 1960s of family planning services by the Ministry of Health (MOH), an egalitarian mindset has prevailed with respect these services. That is, public officials and service providers who have operated the program are committed to the ideal of providing free family planning services to all who seek them, regardless of social class, access to other sources of contraceptives, ability to pay, or other characteristics. Services are also broadly available in the private, commercial sector and, on a more limited basis, through clinics operated by the Sosyal Sigortalar Kurumu (SSK).

In 1994, USAID and the government of Turkey (GOT) announced an agreement whereby contraceptive commodity donations would cease over a five-year period beginning in 1995. That phase-out plan is now in its final year, and by 2000, Turkey will have to finance and procure nearly all contraceptives used in its public sector program. As both contraceptive supplies and technical assistance for the phase-out process near an end, it is important that these processes be documented and assessed. Lessons learned from Turkey can provide valuable insights to stakeholders in Turkey who will continue to face challenges of a newly self-reliant program after the donors are gone, and to donors as they plan phase-outs in other countries. This case study report documents these processes. The principal finding of this case study is that Turkey has made considerable progress towards self-reliance. Some components of a self-reliance strategy are falling into place and there is broad consensus about the remaining components. Still, the process of shifting away from a donor-supplied program is not yet complete. Although the GOT has spent an increasing amount of money to replace donated contraceptives, a sizeable gap remains. Progress has also been made toward implementing alternative financing strategies, such as targeting and cost recovery, to place the public sector program on a sustainable footing; Turkey is preparing to pilot test and implement those strategies.

The GOT's Response

The GOT first procured contraceptives using its own resources in 1997. Trends in quantities of contraceptive supplies purchased and funds spent have increased each year since then. To date, the General Directorate of the Maternal and Child Health/Family Planning (GD MCH/FP) has spent $1.07 million and committed another $700,000 for contraceptive supplies, an amount representing nearly 50 percent of funds needed to fully stock MOH's contraceptive supply system. Although these annual increases in GOT commitments are commendable, that procurement of new products had not kept pace with this distribution volume resulted in a general downward trend in MOH contraceptive stocks. The decline has been steepest for condoms.

In 1999, the MOH purchased condoms equivalent to about a one-year program supply, effectively interrupting the downward trend in stock levels. It will need to purchase more than a one-year supply during the next several program years in order to recover to the desired 15-month level. Although oral contraceptive (OC) supplies are below the desired 15-month cushion, the situation for OCs has not been as problematic, which could change by the end of 1999. The total amount procured or donated to the MOH in 1999 will be about 75 percent of annual need, and the end-of-year OC stock level could thus decline to a nine-month supply, unless additional supplies are purchased. At the beginning of 1999, IUD supplies had not yet been affected by the phase-out schedule, with supplies above the 15-month stock level.

Key Participants in the Phase-out Process

Participants in phase-out activities can be grouped into three categories: implementing groups (those responsible for coordinating strategy development and implementation); technical resource groups

(those with direct roles in providing resources or technical inputs critical to obtaining contraceptive supplies); and support groups (those that provide information and vision to strategy development, planning, and advocacy for self-reliance).

The most important implementing group is the GD MCH/FP, which plays the lead role in planning the response to USAID's phase-out of contraceptive donations. This role was assumed as a natural extension of GD MCH/FP's pivotal responsibility for the national family planning program and for managing contraceptive supplies. The GD MCH/FP was responsible for specifying, quantifying, and justifying self-reliance needs, as well as for mobilizing and using resources for contraceptives. The GD MCH/FP also created broad awareness from the ground up about the challenge it faced in promoting consensus with its self-reliance objectives and generating support for its actions.

The Minister's Office in the MOH is another important implementing group. Its senior staff directly participates at key junctures, such as during budget negotiations and allocation. Bureaucrats at this office also provide technical approval to GD MCH/FP requests for permission to use funds to initiate contraceptive procurement. Earlier in the phase-out period, frequent senior-level changes at the MOH contributed to minimal awareness about and involvement in contraceptive self-reliance strategy development. More recently, senior Minister's Office personnel have been supportive and instrumental in securing resources for contraceptive procurement. Other implementing groups include MOH's Primary Care and Curative Care GDs.

As the chief decision-making body for the public sector budget, the Ministry of Finance (MOF) is the main technical resource group. In the difficult public expenditures environment in Turkey, a mindset among public sector program managers exists that discourages requests for new spending, no matter how small. Dialogue and linkages, however, between the MOH and MOF have increased significantly in the past year, resulting in improved prospects for obtaining adequate funds for contraceptive procurement. Using funds allocated by the MOH, the Department of Administration and Financial Affairs (DAFA) conducts bidding processes for contraceptive procurement at the direction of the GD MCH/FP.

The three principal social insurance schemes in Turkey are also important stakeholder groups in contraceptive self-reliance. Their beneficiaries make up about 60 percent of the MOH family planning clients. The SSK is the largest of these schemes, its beneficiaries constituting 37 percent of MOH's family planning client population. Historically, the MOH provided free family planning services to any beneficiaries of these schemes who sought them. It is in the interest of social insurance scheme managers to participate in defining a sustainable self-reliance strategy to ensure that their beneficiaries have continued access to contraceptives.

As USAID's designated lead technical assistance organization, The POLICY Project (POLICY) is a participant in defining a strategy for Turkey to achieve contraceptive self-reliance. In this role, POLICY provides technical support to the GD MCH/FP and other organizations involved in the self-reliance process.

The State Planning Organization (SPO) is the principal support group, serving planning and coordination functions in state government. As a central body in priority setting, development planning, and donor coordination, the SPO has from the start participated in policy dialogue forums related to contraceptive self-reliance. Commercial sector representatives from the health care industry, especially pharmaceutical suppliers, have participated in policy dialogue about contraceptive self-reliance since the 1995. They have also been the source of contraceptive supplies purchased by the MOH during the phase-out period. Participation by private practice providers is a more recent development. Providers practicing in public clinics and hospitals and local health sector administrators and managers have a greater stake in the outcome of self-reliance efforts; however, their participation has only recently begun. Non-

governmental organizations (NGOs) have participated in policy dialogue forums since 1995. Many of the most active NGOs participate under the auspices of the Turkish Advocacy for Women's Network (KIDOG). USAID played a key role and maintains an abiding interest in supporting the GOT throughout the phase-out process, from defining the overall phase-out strategy to providing contraceptive supplies and technical assistance resources to plan and implement the GOT's self-reliance strategy.

Overview of Phase-out Activities and Processes

The primary challenge facing the GD MCH/FP was obtaining a commitment of financial resources commensurate with the MOH's family planning program needs for contraceptives. Other political and strategic challenges were to (1) inculcate a sense of national responsibility for the national family planning program among a broader constituency inside and outside the MOH; (2) change the sense of entitlement to free family planning services for all that pervaded the program; (3) change strategic thinking in the national program and determine how to target a smaller supply of MOH contraceptives in its program (signaling private sector opportunity to serve the less needy); and (4) overcome resistance, particularly by MOF personnel, to allocating new budget monies for new needs. Principal technical challenges were to (1) institutionalize analytic skills necessary for successful logistics planning; (2) mobilize information about the family planning market structure and public sector program clients needed to develop self-reliance strategy components, such as targeting and cost recovery; (3) develop capacity and skills to use analytic information in advocacy and program planning initiatives within the GD MCH/FP and the MOH Minister's Office; and (4) develop advocacy capacity and skills among NGOs to augment intragovernmental advocacy by public sector agencies. Activities designed to respond to these challenges can be classified as awareness raising, development of technical skills and information base, and advocacy.

Awareness-raising Initiatives

Early efforts focused on creating a broad, general awareness about the phase-out. The objective of the first national self-reliance workshop in December 1995 was to create broad awareness of the GOT's agreement to phase-out and that a response to the agreement had to be mounted. Public, private, and NGO organizations were represented at the workshop, and the group included most of the key informants interviewed for this case study. This activity marked the first time most participants became aware that USAID would be phasing out contraceptive donations to Turkey. Participants broadly pledged to support the MOH, and the GD MCH/FP in particular, to define solutions that would sustain the program in its existing form.

After this workshop, maintaining awareness and attention about the phase-out was difficult. That MOH's contraceptive supply pipeline was well stocked as the phase-out period began reduced the sense of urgency among policymakers to act. As one MOH administrator described the situation at the time, MOH warehouses were "bursting" with contraceptives. In 1997, as MOH contraceptive stocks began to dip below the minimum 15-month stock level, the reality of the phase-out set in and people needed to become aware of the potential of a growing shortfall in the MOH's ability to meet field demand. However, rapid turnover among senior MOH leaders complicated awareness-raising efforts. Building awareness and support within the MOH became a multiyear process. In 1998, when the GD MCH/FP was able to bring the issue to the fore within the Minister's Office, money was released from the Minister's Special Fund for contraceptive purchases. Although the amount allocated fell short of the total resources required to compensate for the loss of donated contraceptives, the fund provided sufficient funds to stave off short-term contraceptive stock-outs. Moreover, this success clearly demonstrated the power of creating awareness among those with control over resources.

Discussions about targeting as a self-reliance strategy component began in 1997. As it became clear that budget resource allocations were falling short of needs, targeting was identified as a way to protect vulnerable MOH client groups. Initially, resistance to targeting was strong. Senior policymakers cited the following two factors as justification: (1) legal restrictions on their ability to adopt anything but a "free for all, without question" approach; and (2) potential public health implications of reducing the level of public sector services. Failure to recognize the imbalance in the benefit-incidence of public contraceptive subsidies across consumer groups also inhibited a willingness to consider adopting an explicit targeting strategy. A market segmentation analysis was conducted to draw attention to the fact that substantial proportions of well-off consumer groups were using MOH family planning services for free, and that these users could crowd out more vulnerable users if contraceptive supplies became constricted. These results were highlighted in a public-private partnership workshop, held in May 1997. Awareness about the broad family planning market structure and MOH's client population created a deeper awareness of the complex dimensions involved in achieving self-reliance, thus opening the door to more serious consideration of targeting as a strategy component.

Willingness to consider alternative funding sources has increased. For example, awareness about the cost of serving social insurance beneficiaries led to consideration of options to secure financial contributions from social insurance organizations. Although these efforts have not resulted in financial burden sharing, they have resulted in stronger support from social insurance organization leaders for public financing to meet MOH's contraceptive procurement needs. MOH client donations, collected through the Health and Social Aid Foundation (HSAF), are another potential alternative financing source for contraceptives in Turkey. A feasibility study was conducted to examine whether seeking donations from family planning clients would be viable, and a pilot study of this cost recovery strategy is in the planning stage.

Although awareness-raising initiatives have been successful, efforts need to continue. Clearly, the level and sophistication of awareness about Turkey's contraceptive self-reliance needs have increased. As implementation nears, key self-reliance strategy components, such as targeting and cost-recovery, raising awareness among new stakeholder groups, which include provincial health administrators, MOH health care facility managers, administrators, providers, and the public at large, will become important.

Development of Technical Skills and Information Base

Information required to achieve self-reliance is information about contraceptive products and budget needs. Up-to-date information on contraceptive stock levels is also required to ensure that procurement processes are initiated with adequate lead-time to prevent supply interruptions at health care facilities. Before the start of the phase-out period, analyses of contraceptive supply needs were completed by outside consultants with little involvement by MOH technical experts. A self-reliant program requires that capacity to generate this information exists within the MOH. In 1997, as policymakers began to consider adding a targeting component to the self-reliance strategy, they also began to seek information about the family planning market structure and client population characteristics. A market segmentation analysis provided that information., which was used to identify population groups considered most in need of subsidized contraceptive products. The market segmentation analysis also played an important role in reshaping attitudes about the responsibility of financing MOH's contraceptive supply needs and the acceptability of targeting supplies to specifically designated groups.

Information about clients' ability and willingness to pay was required to support the consideration of targeting strategies. Willingness-to-pay analyses focused on what costs family planning clients at public health care facilities would be willing to bear. These analyses were conducted within the context of a targeting strategy, whereby non-poor family planning clients were asked to donate part or all of the cost of contraceptives supplied to them. This strategy will likely be administered by the HFAF, since it

already collects donations at nearly all MOH health care facilities. Although important organizational and operational issues need to be investigated further as well as a field trial (scheduled for 2000) before such a strategy could wisely be implemented nationally, the GD MCH/FP and HSAF support this next step toward mobilizing resources from clients.

New needs for information arise over time, and alertness is essential to meet those needs. As the self-reliance strategy is implemented nationally, information to assess operations will be required. It is important that demand for this information come from within the national program once technical assistance from donors is terminated. Similarly, there will be a need for routine information, such as annual contraceptive commodity forecasts and budget requirement estimates. Establishing conditions whereby these analyses are called for and conducted independently of external technical assistance is important to the sustainability of Turkey's self-reliance strategy. A trained four-person team is now in place to ensure that this information is produced on time in future years. Moreover, dissemination of information is as important as its generation. Early dissemination of information will increase the ability for a wider range of stakeholders to participate in policy development, expand the set of alternatives identified to achieve policy objectives, and ultimately create a more supportive constituency for decisions. This, in turn, will improve prospects for successful policy implementation.

Additional issues emerged from the case study about technical capacity for analysis. First, case study respondents recommended that the GD MCH/FP take on more responsibility conducting needed analyses. Also, a strong technical team needs to be constituted. An alternative approach is to create a stronger link between the GD MCH/FP and an academic institution where such analytic skills do exist. Many case study respondents cited a tendency among public policymakers in Turkey to solve problems by crisis response, a tendency not unique to the health sector. Until the power of information to inform good policymaking is more widely accepted, the demand for such analyses will remain less than optimal.

Advocacy

Advocacy efforts to support development of a contraceptive self-reliance strategy can be categorized as internally or externally driven. Both types of advocacy were the most recent components of self-reliance efforts to take hold.

Internal advocacy is defined here as efforts by GD MCH/FP staff to promote their financing and program support needs to compensate for donor phase-out of contraceptive supplies. Targets of internal advocacy would principally be other MOH GDs, the MOH Minister's Office, and the MOF. The early phase-out period was marked by reluctance to engage in internal advocacy, which was no doubt also related to the fact that the phase-out did not begin to impact negatively on supplies until the third year. These early phase-out years were also characterized by lack of a critical mass of information about the impending changes. Regardless of the reason for low internal advocacy activity, the effect was that key decision-makers, especially at the MOH Minister's Office and the MOF, were not sufficiently aware of the need.

In 1997, the first bold internal advocacy action was taken. An unexpected increase in line item 400 funding (consumable supplies) was used to procure contraceptive supplies. Although the amount available was more symbolic than substantive in terms of total need, this act demonstrated that MOH's need was real. It also provided a concrete mechanism to engage the MOH Minister's Office in dialogue about contraceptive self-reliance, given that the first step in the procurement process is to seek the undersecretary's permission to spend funds. This action served as a critical launching pad for subsequent successful internal advocacy efforts. A change in USAID's phase-out schedule of contraceptive deliveries also motivated increased advocacy action by GD MCH/FP staff. In 1997, USAID effectively truncated the phase-out of condoms by two years. The impact on condom stock levels was dramatic,

creating a sense of urgency that had not previously existed. The GD MCH/FP, backed by messages about potential health consequences of inaction, proactively and effectively sought out opportunities to bring this information to senior MOH officials. Internal advocacy achievements were among the most important self-reliance successes. Case study respondents, however, also considered these achievements fragile. For example, the Minister's Special Fund is not considered reliable for long-term contraceptive needs. Respondents also worried that the next minister may not place as high a priority on family planning as the current minister. They expressed that advocacy attention needs to focus on institutionalizing budget support for contraceptives. To that aim, the GD MCH/FP has begun to turn its advocacy efforts to MOF officials.

External advocacy is defined here as efforts by NGOs to encourage and support movement toward defining a sustainable contraceptive self-reliance strategy. An organization that has played an increasingly important role is KIDOG, an umbrella network of NGOs concerned about a wide range of women's issues. In late 1997, KIDOG took an active role in the self-reliance issue. It developed a high profile advocacy campaign designed to bring greater visibility to the need, both to the public and public officials and political leaders who are more difficult to reach through internal advocacy efforts. Most respondents were of the opinion that KIDOG has had a positive impact on raising awareness about self-reliance issues, and that it has been effective in raising the priority level of contraceptive self-reliance as a public policy issue. For example, KIDOG's audience with the president of Turkey in 1998 was widely credited as an important step in gaining high-level policy support for contraceptive financing. KIDOG maintains widespread support in adopting an even stronger role in the self-reliance policy arena.

Self-reliance Is in Sight

The GOT has made great strides in identifying and spending government resources for contraceptives, amounting to almost 50 percent of program needs in 1999. Moreover, there is broad consensus on the other elements of a national self-reliance strategy, namely targeting free supplies to vulnerable groups and cost recovery for the rest. Although the MOH is making steady progress toward self-reliance, it has not yet been achieved. There is the opinion that self-reliance will only be achieved when contraceptive stock levels are at the 15-month cushion of supply. To achieve this within current program parameters, the GOT would have to spend approximately US$5 million per year on a sustained basis. Nevertheless, some of the more notable accomplishments are the following:

- ***Resources*** **-** Turkey has progressed from spending no money on contraceptives in 1996 to spending $645,000 in 1997, $1.5 million in 1998, and nearly $1.8 million in 1999. More importantly, the MOF has verbally committed to fully funding MOH's year 2000 needs for contraceptive procurement, using earmarked, on-budget resources. The MOF has further committed to on-budget financing of contraceptives for a limited (though undefined) period until the other elements of the strategy (targeting and cost recovery) are in place.

- ***Procurement*** **-** Since 1997, the MOH has successfully completed several large contraceptive procurements. The MOH's experience with these procurements has provided many lessons learned and planning has commensurately been adjusted.

- ***Participation*** **-** Many respondents described the strong communication channels that have developed between the GD MCH/FP and commercial pharmaceutical firms as among the most impressive changes occurring during the phase-out period. As the MOH has become more comfortable having these representatives at the policy dialogue table, it has also become more open to participation from other stakeholder groups. Case study respondents also pointed out that inclusion of other GDs and

government agencies in self-reliance policy dialogue and planning is a welcome departure from the standard, more closed policymaking and planning mechanisms that prevail in Turkey's public sector.

- ***NGOs*** **-** KIDOG has provided a tremendous boost to self-reliance advocacy. The network has developed a highly supportive relationship with the GD MCH/FP, successfully reaching high administrative and political levels to increase awareness and lobby for action.

- ***Public Sector Subsidies and Targeting*** **-** A centerpiece of self-reliance policy discussions is presently the GD MCH/FP's intention to employ a targeting approach to achieve contraceptive self-reliance. Targeting is intended as a means of raising the resources needed to keep MOH's service delivery system well supplied with contraceptives. According to the plan, poor clients will continue to receive their contraceptive method for free. Non-poor clients will be asked to contribute to the cost of contraceptives. Respondents also described challenges that will need to be dealt with to successfully implement a targeting strategy. The most commonly named challenge is the need to devise a sound management system. In addition, resistance to the concept of targeting remains strong in some quarters. Continued efforts are needed to build a broader foundation of support.

Case study respondents suggested additional steps that would facilitate the final stages of developing and implementing the self-reliance strategy. For instance, the time is right to draw local health administrators, managers, and providers into policy dialogue. Organized representation of private practice physicians was mentioned as another desired input. Respondents also suggested that efforts continue that will increase awareness about contraceptive self-reliance needs among decision-makers in social insurance organizations. They expect strong support once these leaders are fully aware and involved in policy dialogue and planning. Continued active involvement of senior leaders, rather than their designated mid-level staff, will also contribute to expeditiously carrying out the final steps in achieving self-reliance.

Continued, perhaps even intensified, effort and vigilance will be required to take the final steps, and technical assistance will play a useful role in supporting such efforts. The most useful elements to focus on now are putting a rational targeting strategy in place that includes a cost recovery mechanism; drawing local health administrators, managers, and providers into dialogue and planning; and maintaining the awareness, attention, and support of senior, influential decision makers.

One case study respondent said, "The GD MCH/FP has learned to fight for its needs; this has made all the difference in the pace of progress towards self-reliance." In the new environment at the GD MCH/FP and with this "fighting spirit" and increasingly participatory approach to policy dialogue and planning, there is reason to be optimistic about the prospects for Turkey's family planning program.

Case Study of Contraceptive Self-reliance Efforts in Turkey: Prospects and Lessons Learned

I. INTRODUCTION

Turkey is a fast-developing country with a dynamic economy. The country boasts a successful and progressive population and family planning program, although progress in that program, as measured by growth in contraceptive prevalence, appears to have slowed. According to results from the 1998 Turkey Demographic and Health Survey (DHS), population program indicators have not changed significantly from those measured from the 1993 DHS. Total contraceptive prevalence stands at 64 percent, and four out of 10 of these contraceptors use a non-modern method such as withdrawal. The total fertility rate stands at 2.6, which represents a small decline from the early 1990s.

Although the private commercial sector presently plays an effective role in the national family planning market, the public sector has historically played a dominate role, especially in the market for IUDs and surgical sterilization. In the public program, contraceptives are distributed mostly through the Ministry of Health's (MOH's) extensive network of hospitals and primary health care facilities. Until recently, international donors have been the source for nearly all contraceptive supplies distributed by the MOH. Among the donors, the U.S. Agency for International Development (USAID) provided more than 90 percent of these supplies every year since the 1960s.

In USAID's history of development assistance to Turkey, the population and family planning program was the last program scheduled to be phased out. Discussions about the phase-out of assistance to the program were first held in 1989. Certain program considerations delayed implementation of a population program phase-out plan for several years thereafter. In 1994, USAID and the government of Turkey (GOT) announced an agreement whereby contraceptive commodity donations would cease. That phase-out plan is now in its final year and, by 2000, Turkey will have to finance and procure nearly all contraceptive commodities used in its public sector program.

Beginning in 1995, USAID has provided technical assistance to help Turkey respond to the phase-out of contraceptive supplies, primarily through the OPTIONS II and the POLICY Projects. As both contraceptive supplies and technical assistance for the phase-out near an end, it is important that these processes be documented and assessed. Lessons learned from Turkey can provide valuable insights to stakeholders in Turkey who will continue to face challenges of a newly self-reliant program after the donors are gone, and to donors as they plan phase-outs in other countries. This case study documents these processes. A key informant interview approach was used to collect information about phase-out activities from a broad range of stakeholders in Turkey. Results from these interviews are woven into information from a review of analyses and documents produced during this phase-out process.

The principal finding of this case study is Turkey has made considerable progress toward self-reliance. Some components of a self-reliance strategy are falling into place, and there is broad consensus about the remaining components. Still, the process of shifting away from a donor-supplied program is not yet complete. Given the economic and political context in which this phase-out has occurred and the relatively short period of time Turkey has had to plan its response, the progress witnessed is commendable. Although the milestones achieved provide much to be proud of, many stakeholders in Turkey are mindful of the need for continued high-level attention to self-reliance activities. The GOT spent an increasing amount of money replacing donated contraceptives, but a sizeable gap remains. Progress has also been made toward implementing alternative financing strategies, such as targeting and

cost recovery, to place the public sector program on a sustainable footing; Turkey is preparing to pilot test and implement those strategies.

Section II of this report describes the national family planning program, the phase-out, and the context into which this phase-out has occurred. Section III describes key participants and stakeholders in the phase-out process. Section IV describes technical activities implemented since 1995 to respond to the phase-out. The impact and shortcomings of these activities are also described using information gathered from case study key informants. Section V assesses where the national program is now as well as program prospects and challenges as Turkey enters the era of complete self-reliance. This section also draws heavily on responses from case study key informants, lays out several key lessons learned of the phase-out process, and provides recommendations for action within Turkey's national family planning program. This final section will be useful to donors as they plan for phase-out of donor assistance to family planning and other country programs.

II. BACKGROUND

A. National Program

The MOH began providing family planning services in 1965 after adoption of Population Planning Law #557, which legalized contraception and assigned responsibility for providing contraceptive services to the MOH. The current constitution, passed in 1982, and Family Planning Law #2827, adopted in 1983, broadened the availability of methods and increased access to services by liberalizing service provision regulations. Within the MOH, the General Directorate for Maternal and Child Health/Family Planning (GD MCH/FP) presently oversees the national family planning program, including the management of public sector contraceptive supplies. Since the inception of family planning services by the MOH, an egalitarian mindset has prevailed with respect to these services. Public officials and service providers, who have operated the program, are committed to the ideal of providing free family planning services to all who seek them, regardless of their social class, access to other sources of contraceptives, ability to pay, or other characteristics. Turkey's constitution has often been cited as the chief justification and legal imperative for this prevailing program orientation.[1]

Since the 1960s, the sources of family planning services available to Turkish couples have diversified. Services are broadly available within the MOH's network of facilities, including specialized family planning clinics, hospitals, and integrated primary health care facilities. Family planning services are also now widely available in the private commercial sector and, on a more limited basis, through clinics operated by the country's largest social security organization, the Sosyal Sigortalar Kurumu (SSK). Condoms, pills, and IUDs are the three most widely used modern contraceptive methods. Injectable contraceptives have recently been made available at some MOH service delivery sites and are now registered for sale in the commercial sector. Table 1 summarizes the major components of Turkey's family planning market in 1998.

[1] Article 41 of the Constitution reads, "The State shall take the necessary measures and establish the necessary organization to ensure the peace and welfare of the family, especially the protection of the mother and children and for family planning education and application." The meaning of *ensure* is often debated in Turkish policy circles. Proponents of the prevailing, untargeted program orientation interpret *ensure* to mean that the state is required to *provide* family planning services without charge and without question to all who seek them. Other policymakers interpret *ensure* as meaning that the state must provide for a mix of public and private sectors in service delivery. In this interpretation, the state should promote the private sector's role among population segments that can afford their services, serving a regulatory role to ensure quality and access. The state's role as a service provider would thus be limited to population groups with poorer access to private services.

Table 1
Family Planning Market Shares in Turkey, 1998 (%)

Method	Public	SSK	Commercial Sector	Other	Total
Condoms	27.7	0.0	66.8	5.5	100
Pills	24.4	1.6	73.6	0.4	100
IUDs	65.6	6.3	27.6	0.5	100

Source: 1998 Turkey Demographic and Health Survey (Table 4.11, page 56).

B. Context for Phase-out

As noted, USAID contraceptive commodity donations to Turkey were initiated during the 1960s. Since then, the public sector family planning program, including services provided through SSK outlets, has been almost totally reliant on donated contraceptives. Several factors motivated the phase-out of donor assistance in Turkey. First, Turkey has achieved a relatively high degree of social and economic development; it is classified as a middle-income country. As Turkey continues to progress, its ability to meet its own development needs increases. Indeed, USAID has phased out assistance to all sectors in Turkey other than family planning. For about a decade, the prevailing sense among USAID and GOT decision-makers is that, with appropriate political and social commitment, Turkey should be able to meet its program needs without donor assistance.

Mitigating against USAID's phase-out of family planning program assistance is the harsh reality of Turkey's public sector finance environment. Although Turkey continues to thrive in terms of overall GDP growth, government finances are not commensurately strong.[2] Throughout most of the 1990s, Turkey has experienced inflation rates near 100 percent and the government has persistently run high budget deficits. Repeatedly, the GOT has sought international assistance to help restructure its budget. Rapid turnover in national political administrations, however, has frustrated most of these attempts, and progress toward structural adjustment goals has been slow. Currently, the public sector budget operates under austere conditions. Proposing new public sector spending, even small amounts such as the amount needed to finance contraceptive supplies, is extremely difficult.

Against this background, in 1994 the GOT and USAID announced an agreement to phase-out contraceptive supply donations in five years, beginning in 1995. The first reduction in contraceptive donations occurred in 1996, and 1999 is the final year USAID will donate any contraceptives.

C. Phase-out Plan

Prior to announcing this agreement, the GOT and USAID considered several alternative contraceptive phase-out schedules. Mutually consistent interests on both sides resulted in selecting the phase-out sequence shown in Table 2. Fully aware of the difficult public sector budgeting environment, the GOT was concerned about costs and preferred the alternative that minimized the short-term and overall cost during the phase-out period. For its part, USAID sought to protect its long-standing investment in Turkey's family planning program and its gains in women and children's health. The chosen approach gradually phased out condom and oral contraceptive (OC) donations by one-fifth (20%) each year, protecting IUD donations until the fourth year. IUDs, the backbone of the public sector's

[2] Average GDP growth from 1988–1996 was 4 percent. Average GNP growth from 1981–1996 was 4.8 percent. (Source: State Planning Office and State Institute of Statistics, Turkey.)

program, constitute 52 percent of modern method use. In addition, the MOH maintains a 66 percent share of the total market for IUDs in the country.

Table 2
Schedule for Phase-out of USAID Contraceptive Commodity Donations to the Government of Turkey (% share)

Phase-out Year	Commodity	USAID Donations	GOT/MOH Responsibility
1996 (year 1)	Pills and Condoms	80	20
	IUDs	100	0
1997 (year 2)	Pills and Condoms	60	40
	IUDs	100	0
1998 (year 3)	Pills and Condoms	40	60
	IUDs	100	0
1999 (year 4)	Pills and Condoms	20	80
	IUDs	50	50
2000 (year 5)	Pills and Condoms	0	100
	IUDs	0	100

The phase-out schedule was amended in 1997 when USAID contributed only 44 percent of condom requirements rather than the planned 60 percent. In that year, USAID also announced that in 1998 no condoms would be donated to Turkey, effectively cutting short the planned phase-out for condom donations by two years. This change was necessitated by changes in U.S. government support for international population programs.

D. The GOT's Financial and Procurement Response

Table 3 shows trends in quantities of contraceptive supplies purchased by the GOT, beginning in 1997, and Figure 1 (page 6) shows the trajectory of funds spent by the GOT to buy these supplies. Both show a clear upward trend, especially for condoms for which supply need is greatest, in the GOT's commitment of resources. Procurement figures for 1999 shown in Table 3 represent completed procurement processes; however, they do not include contraceptives that will be delivered when the current procurement process is completed for another $700,000. The MOH has purchased few IUDs to date because its stock supply remains at its desired 15-month supply level (see Figure 2, page 7).

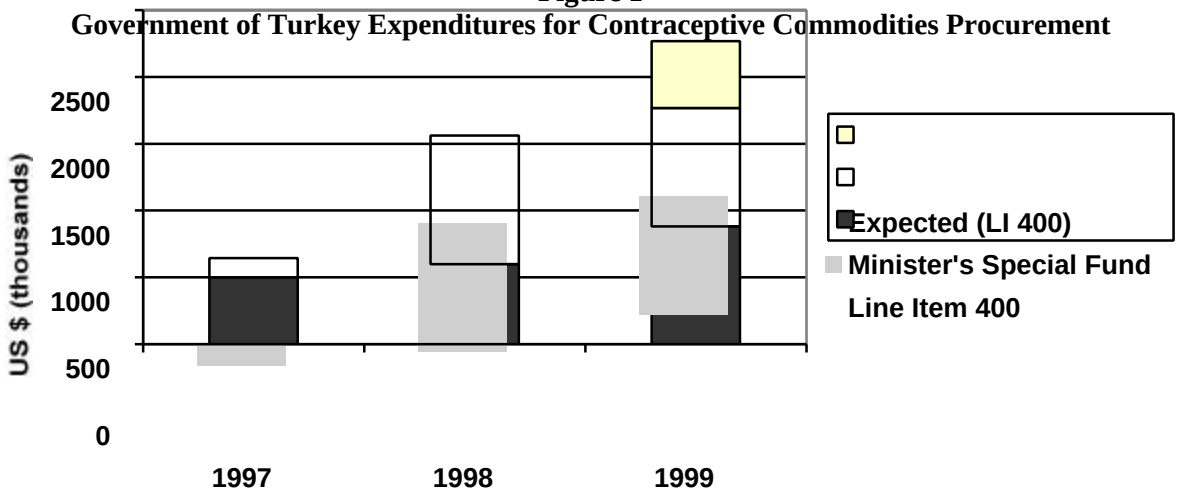
Table 3
Contraceptives Procurement by the Government of Turkey

Phase-out Year	OCs	IUDs	Condoms	Injectables	
	(Cycles)	(Pieces)	(Pieces)	1-month (Doses)	3-month (Doses)
1997	187,352	0	6,070,822	0	0
1998	762,281	3,278	20,270,058	36,000	27,423
1999	583,200	0	21,926,400	40,400	0

The GD MCH/FP budgeted a small amount of money for a trial procurement of contraceptives in 1996, the first year of phase-out implementation. The MOH undersecretary's approval to initiate a procurement process was obtained and the process initiated. However, the process was canceled because of an end-of-year, government-wide order prohibiting further public purchases. Fortunately, MOH contraceptive stocks remained sufficient that year to supply its service delivery system. In 1997, the GD MCH/FP's budget line item for consumable supplies (line item 400) was increased by nearly US$500,000. Although not specifically designated for contraceptive supplies, senior GD MCH/FP staff used these new resources to complete the GDs first contraceptive procurement. The GD MCH/FP also secured additional resources that year from the Minister's Special Fund, and in total spent $643,000 on contraceptives.[3] Although the volume of contraceptives purchased in 1997 fell short of the amount needed to compensate for decreased USAID donations, this success served as an important test run of the procurement system.

In 1998, the amount of money allocated from the Minster's Special Fund increased significantly to $962,000. In total, the GD MCH/FP spent $1.56 million on contraceptives, representing about 40 percent of the amount needed to fully stock the MOH supply system. Whereas this increase was dramatic evidence of the GOT's serious intent to achieve self-reliance, the amount of contraceptives purchased fell short of needed supplies. To date, the GD MCH/FP has mobilized and spent $1.07 million on contraceptives, 83 percent of which was from the Minister's Special Fund. At the time of this writing, the MOH was completing a purchase of more contraceptives, using $700,000 from the GD MCH/FP's line item 400. Another $500,000 may be spent from line item 400 later in 1999. With the $1.77 million already spent or committed in 1999, the MOH will have spent nearly 50 percent of funds needed to fully stock its contraceptive supply system.

Figure 1
Government of Turkey Expenditures for Contraceptive Commodities Procurement



[3] The Minister's Special Fund (also known as Fund 39A, codified as Law 3418) is a pool of public resources provided to the Minister of Health for special needs for which the regular budget does not provide. These funds are derived from special earmarked taxes (32 percent earmarked for the MOH) and fall outside the rules and regulations of the regular government budget. Decisions about how to use these funds are the minister's alone. Although these funds have been important to the short-term response to USAID's contraceptive phase-out, the emergency nature of these funds makes them an unreliable source for long-term family planning program support.

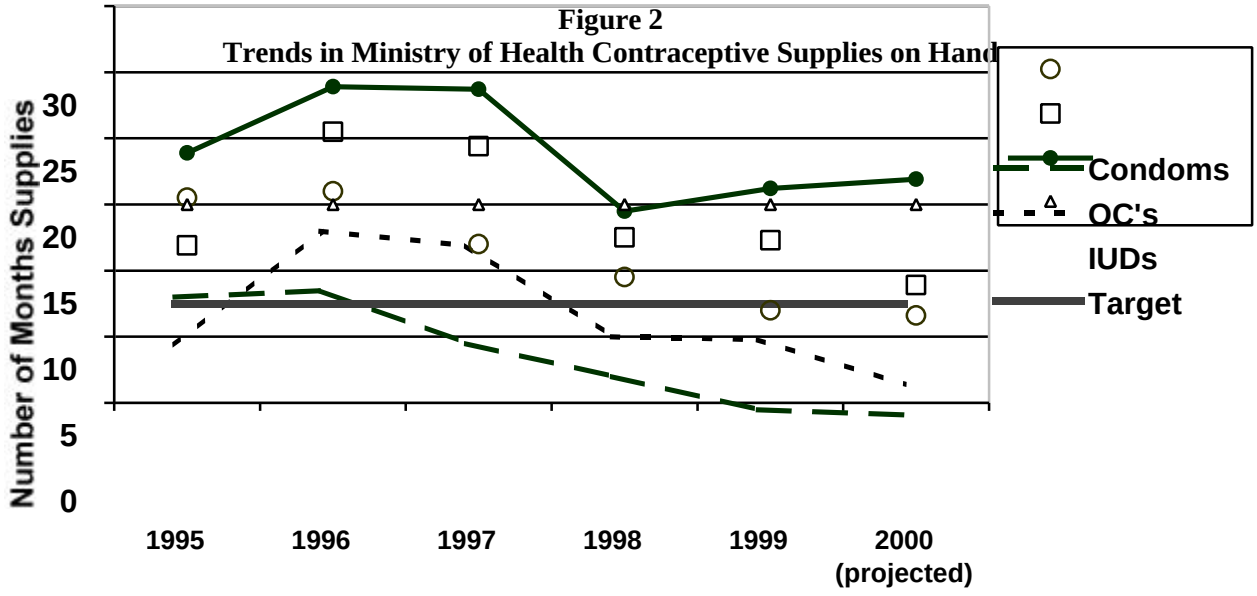
E. Trends in MOH Contraceptive Supplies

Turkey's contraceptive logistics supply policy is to maintain at least a 15-month supply of each method it provides to clients at its health care facilities. Figure 2 shows the trend in supplies for condoms, OCs, and IUDs, expressed as the number of months' supply in the logistics supply system at the beginning of each phase-out year.[4] A downward trend is generally observed across the phase-out period for each of the three main public sector program methods. The decline was steepest for condoms. MOH health facilities distribute more than two million condoms per month, and until 1999 procurement of new product had not kept pace with this distribution volume. In 1999, the MOH purchased condoms equivalent to about a one-year program supply, effectively interrupting the downward trend in stock levels. It will need to purchase more than a one-year supply during the next several program years in order to recover to the desired 15-month level.

A near crisis in condom supplies in September 1998 demonstrated the need to initiate procurement processes well in advance of anticipated program supply needs. At that time, the MOH experienced a sharp stock decline to a one-month supply of condoms because of an unexpected delay in the shipment of supplies purchased earlier that year. Stocks recovered to an approximately six-month supply level soon after the beginning of the year when the shipment arrived. The MOH has since adjusted its procurement planning process to account for potential delays in shipments from suppliers.

Although OC supplies are below the desired 15-month stock level, the situation for OCs has not been as problematic, due in part to high inventories and donated supplies that continued to flow in at a rate of 40 percent of the program's annual need in 1998. This situation could change, however, by the end of 1999. USAID shipments in 1999 amounted to about 20 percent of the public sector program need; the MOH purchased about another 30 percent of its annual program need and initiated procurement for another 25 percent. The total amount procured or donated to the MOH in 1999 will, therefore, be about 75 percent of annual need. Thus, the end-of-year OC stock level could decline to a nine-month supply unless additional supplies are purchased in 1999.

Figure 2
Trends in Ministry of Health Contraceptive Supplies on Hand



[4] Phase-out year refers here to the GOT's fiscal year, which begins January 1.

At the beginning of 1999, IUD supplies had not yet been affected by the phase-out schedule, with donated supplies meeting all of the program's annual needs in 1998. However, the GOT will need to purchase IUDs in 2000 to prevent stocks from declining as donated supplies will cease after 1999.[5]

III. KEY PARTICIPANTS AND STAKEHOLDERS IN THE PHASEOUT PROCESS

Participants in phase-out activities are grouped in three categories:

- Implementing groups—those responsible for coordination of strategy development and implementation;
- Technical resource groups—those with direct roles in providing resources or technical inputs critical to obtaining contraceptive supplies; and
- Support groups—those who provide information and vision to strategy development, planning, and advocacy for self-reliance.

Each of these groupings is described below, along with an analysis of the role each group has actually played and opportunities to develop better linkages among them.

A. Implementing Groups

The GD MCH/FP plays the overall lead role in planning the response to USAID's phase-out of contraceptive donations. This role was assumed as a natural extension of the GD MCH/FP's pivotal responsibility for the national family planning program and for managing contraceptive supplies. The GD MCH/FP was given great independence to respond to the phase-out; direction from higher levels in the MOH was minimal.[6] The GD MCH/FP was responsible for specifying, quantifying, and justifying self-reliance needs. It was also responsible for mobilizing and using resources for contraceptives. The GD MCH/FP was to assess the degree to which its actions were closing the gap left by USAID and develop strategies to augment the typical approach of obtaining government budget resources. Since there was no call from higher authorities for this leadership and information, the GD MCH/FP also created broad awareness from the ground up of the challenge it faced in promoting consensus with its self-reliance objectives and generating support for its actions.

The minister, undersecretary, and deputy undersecretaries constitute the senior staff at the Minister's Office in the MOH. Theoretically, this office would provide a clear mandate and guidance to the GD MCH/FP by establishing self-reliance objectives and overseeing the GD MCH/FP's actions and progress. Senior staff at the Minister's Office also directly participate at key junctures, such as during budget negotiations and allocation. In addition, bureaucrats at this office provide technical approval for the GD MCH/FP requests for permission to use funds to initiate bidding processes for contraceptive procurement. Earlier in the phase-out period, frequent senior-level changes at the MOH contributed to minimal awareness about and involvement in providing guidance and oversight of the GD MCH/FP on contraceptive self-reliance. More recently, senior Minister's Office personnel have been not only supportive, but also instrumental in securing resources and for contraceptive procurement. A much more cooperative and facilitative environment now exists between the Minister's Office and the GD MCH/FP.

[5] According to the phase-out plan for IUDs, USAID was to ship 50 percent of MOH's expected annual program consumption in 1999, amounting to 166 IUDs. In fact, USAID shipped 342 IUDs in 1999.

[6] This situation in part may have derived from the fact that historically, contraceptive supplies were completely donor-provided, with no need for MOH leaders at higher levels to be involved with contraceptive logistics.

The Primary Care and Curative Care GDs are considered to be implementing groups in that they administer most MOH health care facilities (except the MCH/FP facilities, which are administered by the GD MCH/FP), where the vast majority of the ministry's contraceptive supplies are distributed. As such, they have a vested interest in participating in efforts to secure resources needed to keep their family planning clinical and supply services functioning. Early in the phase-out period, senior officials at these GDs assigned mid-level staff to policy dialogue forums sponsored by the GD MCH/FP. More recently, senior staff in these GDs have become more aware of the contraceptive self-reliance issue, have recognized the potential consequences of the phase-out, and have taken on an active role in promoting strategies to achieve self-reliance.

B. Technical Resource Groups

As the chief decision-making body for the public sector budget, the Ministry of Finance (MOF) plays a critical role in responding to the country's need to achieve contraceptive self-reliance. The MOF is the most important arbiter of sectoral budgets, defining the amount of money the MOH will have to allocate across its many GDs and functions. MOF staff also review MOH budget plans at the GD level, examining proposed spending for each GD, line item by line item. In the difficult public expenditures environment in Turkey, a mindset among public sector program managers exists that discourages requests for new spending, no matter how small. However, dialogue and linkages between the MOH and MOF have increased significantly in the past year, resulting in improved prospects for obtaining adequate funds for contraceptive procurement.

While the MOF is responsible for front-end resource allocation decisions, the MOH's Department of Administration and Financial Affairs (DAFA) is responsible at the other end. After resources have been allocated, the DAFA conducts bidding processes for contraceptive procurement at the direction of the GD MCH/FP.

There are three principal social insurance schemes in Turkey, and the beneficiaries of these constitute about 60 percent of the MOH family planning clients. The SSK is the largest of these schemes, covering commercial sector employees and manual workers in the public sector. SSK beneficiaries make up 37 percent of MOH's family planning client population. Together, Bag Kur, which covers small business people and artisans, and civil service social insurance schemes make up another 23 percent of MOH's family planning client population. Each of these schemes provides some degree of health benefits to their beneficiaries; however, historically the MOH provided free family planning services to many persons in these groups who sought them. However, it is in the interest of social insurance scheme managers to participate in defining a sustainable self-reliance strategy to ensure that their beneficiaries have continued access to contraceptives. There is a constituency to the opinion that social insurance schemes will have to accept an increased burden of financing and providing family planning services to their beneficiaries.

As USAID's designated lead technical assistance organization, The POLICY Project (POLICY) is a participant in defining a strategy for Turkey to achieve contraceptive self-reliance. In this role, POLICY provides technical support to the GD MCH/FP and to other organizations involved in the self-reliance process.

C. Support Groups

The State Planning Organization (SPO) serves planning and coordination functions in state government. As a central body in priority setting, development planning, and donor coordination, the SPO has from the start participated in policy dialogue forums related to contraceptive self-reliance. Commercial sector representatives in the health care industry are relatively new participants in health

policy dialogue in Turkey. Pharmaceutical suppliers have participated in policy dialogue about contraceptive self-reliance since the first national workshop in 1995. They have also been the source of contraceptive supplies purchased by the MOH during the phase-out period. Conversely, participation by private practice providers is a more recent development. Providers practicing in public clinics and hospitals are also important stakeholders in self-reliance initiatives but have not yet been consistently involved in policy dialogue. Similarly, local health sector administrators and managers have a greater stake in the outcome of self-reliance efforts; their participation has only recently begun to develop.

Nongovernmental organizations (NGOs) have participated in policy dialogue forums since in 1995, and the degree of their involvement has expanded considerably. Many of the most active NGOs participate under the auspices of the Turkish Advocacy for Women's Network (KIDOG). While the concept of NGOs as watchdogs of public agencies is a relatively new role in Turkey, KIDOG has adopted an increasingly proactive advocacy role in support of the GD MCH/FP's self-reliance initiatives.

USAID played a key role and maintained an abiding interest in support of the GOT throughout the phase-out process, from defining the overall phase-out strategy to providing contraceptive supplies and technical assistance resources to plan and implement the GOT's self-reliance strategy. USAID cooperating agency projects other than POLICY (including SOMARC, AVSC, JHU [JHPIEGO and PCS], MSH/FPMD, and JSI/SEATS) also play an important role in supporting efforts to define and implement self-reliance strategies. PATH, through FPLM Project, made an important contribution to dialogue on commodity procurement options.

IV. OVERVIEW OF PHASE-OUT ACTIVITIES AND PROCESSES

As noted in the previous section, the GD MCH/FP is the principal implementing agency responsible for leading the response effort during the contraceptive phase-out period. The primary challenge facing the GD MCH/FP has been to obtain a commitment of financial resources commensurate with the MOH's family planning program needs for contraceptives. Other technical and political and strategic challenges became apparent during the course of the phase-out period. Activities undertaken by the GD MCH/FP and its technical assistance partners have evolved to respond as these new challenges became apparent. Primary political and strategic challenges were to

- Inculcate a sense of national responsibility for the national family planning program among a broader constituency inside and outside the MOH;
- Change the sense of entitlement to free family planning services for all that pervaded the program;
- Fundamentally change strategic thinking in the national program and determine how to target a smaller supply of MOH contraceptives in its program (signaling private sector opportunity to serve less needy clients); and
- Overcome resistance, particularly by MOF personnel, to allocating new budget monies for new needs.

Principal technical challenges were to

- Institutionalize analytic skills necessary for successful logistics planning (commodity and budget forecasting to procure the right kinds and the right amounts of contraceptives at the right time);
- Mobilize information about the family planning market structure and public sector program clients needed to develop self-reliance strategy components, such as targeting and cost recovery;
- Develop capacity and skills to use analytic information in advocacy and program planning initiatives within the GD MCH/FP and the MOH Minister's Office; and

- Develop advocacy capacity and skills among NGOs to augment intra-governmental advocacy by public sector agencies.

Table 4 summarizes the major activities conducted since 1995 to support the response effort to the contraceptive phase-out in Turkey.[7] These activities can be classified in three categories: awareness raising, development of technical skills and information base, and advocacy.

A. Awareness-raising Initiatives

A.1 Creation of General Awareness

Early efforts focused on creating a broad, general awareness about the phase-out. Raising awareness in the early stages was perhaps easier than later because the concept was defined more generally. The objective of the first national self-reliance workshop in December 1995 simply was to create a broad awareness of the GOT's agreement to a phase-out plan and that a response to the agreement had to be mounted. Public, private, and NGO organizations were represented at the workshop, and the group included most of the key informants interviewed for this case study. Without exception, all key informants rated this activity as the turning point in the self-reliance process; it marked the first time most participants became aware that USAID would be phasing out contraceptive donations to Turkey. Participants broadly pledged to support the MOH and the GD MCH/FP in particular, to define solutions that would sustain the program in its existing form.

[7] Reports and background documents for these activities are listed in Appendix A.

Table 4
Major Self-reliance Technical Assistance Activities in Turkey

Activity	Date	Objectives
1. National self-reliance workshop	December 1995	▪ Generate broad awareness of phase-out. ▪ Generate options for self-reliance strategy.
2. Contraceptive procurement tables (CPT analyses)	April–May, annually	▪ Assess current contraceptive stock supplies. ▪ Forecast next year's procurement needs.
3. Contraceptive budget forecasts	May–June, annually	▪ Forecast next year's financial requirements for contraceptive procurement.
4. Contraceptive procurement mapping workshop	August 1996	▪ Generate understanding of the contraceptive procurement process in Turkey. ▪ Establish linkages among actors and stakeholders in the process.
5. Market segmentation analysis	November 1996–February 1997	▪ Describe structure of the family planning market in Turkey. ▪ Examine degree to which MOH commodities are targeted to "high need" groups. ▪ Examine commercial sector market niches and examine its growth potential.
6. Public-private partnership workshop	May 1997	▪ Identify opportunities to increase commercial sector role in family planning service delivery. ▪ Initiate policy discussion on targeting as a component of national self-reliance strategy.
7. Development of targeting strategy alternatives	December 1997–May 1998	▪ Present policymakers with alternatives for distributing contraceptive supplies.
8. KIDOG informational meetings	October 1997–ongoing	▪ Provide KIDOG with technical information to plan self-reliance advocacy initiatives.
9. KIDOG self-reliance advocacy campaign	April 1998–ongoing	▪ Alert policymakers and public of potential family planning program crisis. ▪ Influence public officials to allocate and use funds to purchase contraceptives.
10. Government meetings to define targeting strategy	August and November 1998, January and September 1999	▪ Broaden participation among MOH leaders in targeting decision-making process. ▪ Generate support among relevant government agencies. ▪ Identify a preferred strategy and to initiate operational planning.
11. Health and Social Aid Foundation (HSAF) assessment	November 1998–March 1999	▪ Assess potential for HSAF to mobilize resources from MOH family planning clients for MOH contraceptive procurement.
12. Develop operational plan for GD MCH/FP targeting strategy.	December 1998–ongoing	▪ Develop sound plan for implementation of targeting strategy. ▪ Develop pilot test protocol.

After this workshop, maintaining awareness and attention about the phase-out was difficult. That MOH's contraceptive supply pipeline was well stocked as the phase-out period began reduced the sense of urgency among policymakers to act. Misunderstanding about when reductions in USAID shipments would begin also reduced interest in dialogue about self-reliance. In 1996, when USAID condom shipments were to make up only 80 percent of the MOH's projected need, more than 100 percent was delivered to Turkey. Due to high levels of USAID shipments, often more than 100 percent of annual program consumption, IUD stocks also remained well over the desired 15-month level during the first three phase-out years. Also, OC stocks remained well over the 15-month supply level during the first two years of the phase-out period. As one MOH administrator described the situation at the time, MOH warehouses were "bursting" with contraceptives.

In 1997, as MOH contraceptive stock levels began to dip below the 15-month minimum, the phase-out became real, thus creating a new opportunity to generate awareness. People needed to become aware of the potential of a growing shortfall in the MOH's ability to meet field demand. This new message was decidedly more downbeat, and consensus building about a self-reliance strategy became more difficult. It was during this stage that KIDOG stepped into the awareness-raising arena (its role and approach are described in Section C below).

A.2 Challenges

Rapid turnover among senior MOH leaders complicated awareness-raising efforts. General directors at key MOH program departments changed periodically, necessitating repeated efforts to brief new leaders about the contraceptive phase-out. There was also rapid turnover at the MOH's, where support was critical to self-reliance progress, and awareness is a necessary precondition to support. Without it, the annual public sector budget was unlikely to yield more than marginal resources for MOH contraceptive purchases. The political nature of the Minister's Office further complicated ability to keep awareness high. Political connections and personal relationships are as important to gaining access to this office as are the merits of the issue. Building awareness and support within the MOH was a multiyear process.

In 1998, when the GD MCH/FP was able to bring the issue to the fore within the Minister's Office, money was released from the Minister's Special Fund for contraceptive purchases.[8] The Health Minister alone decides how to use this emergency discretionary fund. Although the amount allocated from this fund fell short of the total resources required to compensate for loss of donated contraceptives, the fund provided sufficient funds to stave off contraceptive stock-outs in the short term. Moreover, this success clearly demonstrated the power of creating awareness among those with control over resources.

A.3 Progress

Discussions about targeting as a self-reliance strategy component began in 1997. As contraceptive stocks began to dwindle and budget resource mobilization efforts were not producing desired results, awareness about the MOH's family planning client population needed to be raised. Specifically, the potential impact of the existing untargeted program approach on poor and otherwise vulnerable MOH clients needed to be examined. Targeting was presented as a self-reliance strategy component to protect these vulnerable client groups. Initially, resistance to this idea was strong. Public officials in the GD MCH/FP and other organizations insisted that full public financing and continued untargeted service provision was the only acceptable solution to the phase-out. This attitude also prevailed among leaders in many agencies outside government. Twin rationales invoked by GD MCH/FP senior staff were (1) legal restrictions on their ability to adopt anything but a "free for all, without

[8] See footnote 4 for description of the Minister's Special Fund.

question" approach, and (2) potential public health implications of reducing the level of public sector services. Also, failure to recognize the imbalance in the benefit-incidence of public subsidies across consumer groups inhibited willingness to consider adopting an explicit targeting strategy. [9]

A market segmentation analysis was conducted to draw attention to the fact that substantial proportions of well-off consumer groups were using MOH family planning services for free, and that these users could crowd out more vulnerable users if contraceptive supplies became constricted. These results were highlighted in a public-private partnership workshop, held in May 1997. This workshop was designed to promote more serious consideration of targeting as a component of national self-reliance strategy. Awareness about the broad family planning market structure and MOH's client population created a greater awareness of the complex dimensions involved in achieving self-reliance; that is, public financing is but one dimension of the solution.

Willingness to consider alternative funding sources has increased. Early in the public debate about strategies to achieve self-reliance, most stakeholders found it unacceptable to discuss funding sources other than the public sector budget. After three years of poor outcomes from efforts to increase the GD MCH/FP budget for contraceptives, stakeholders became more willing to consider other resource options, thus creating a new need to raise awareness about alternative financing sources. For example, awareness about the cost of serving social insurance beneficiaries led to a consideration of options to secure financial contributions from social insurance organizations.[10] However, the SSK is widely perceived to be in fragile financial health and unable to contribute substantially to cost of meeting its beneficiaries' demand for contraceptives. Though these efforts have not resulted in financial burden sharing, they have resulted in stronger support from SSK leaders for public financing to meet MOH's contraceptive procurement needs.

MOH client donations, collected through the HSAF, are another potential alternative financing source for contraceptives in Turkey. Most of the funds collected are used to support operating expenses at MOH facilities, where they are collected; however, family planning clients are generally not asked to make donations for contraceptive supplies. A feasibility study was conducted to examine whether seeking donations from family planning clients would be viable.[11] Results from this feasibility study are being used in policy dialogue forums to further broaden awareness about self-reliance needs and to generate support for developing and implementing this cost-recovery strategy.

A.4 Continued Awareness-raising Needed

Although awareness-raising initiatives have been successful, efforts need to continue. Clearly, the level and sophistication of awareness about Turkey's contraceptive self-reliance needs have increased. For key organizations such as the GD MCH/FP, the MOH Minister's Office, and the SPO, case study respondents described awareness as high. Respondents reported that awareness among leaders at the MOF is not yet as high as it needs to be. Although leaders at MOH's Primary Care and Curative Care GDs have recently been more participatory in self-reliance policy dialogue, case study respondents said there is still room for improvement in awareness about the dimension and options for self-reliance

[9] Benefit-incidence is the degree to which different consumer groups capture public subsidies for family planning services.

[10] That social insurance beneficiaries constitute 60 percent of MOH's family planning client population was mentioned above. The SSK has a health services delivery system, and the other social insurance organizations have arrangements to finance health services for their beneficiaries.

[11] Collecting donations for contraceptives distributed at MOH health care facilities would bring family planning services in line with nearly all other services at these facilities, for which the HSAF currently collects donations from clients. Revenue raised is used to augment local, regional, and national health sector needs that the MOH budget is not able to meet.

strategies. Building and maintaining awareness is always ongoing, and the GD MCH/FP is striving to better integrate leaders of these organizations into contraceptive self-reliance policy dialogue. For instance, in September 1999, the GD MCH/FP succeeded in bringing senior representatives from six government agencies and two social insurance organizations together to build consensus on a national contraceptive self-reliance strategy. As implementation nears for key self-reliance strategy components, such as targeting and cost-recovery, maintaining awareness and involvement among these senior policymakers and raising awareness among new stakeholder groups, such as provincial health administrators, MOH health care facility managers, administrators, providers, and the public at large, will be essential.

B. Development of Technical Skills and Information Base

B.1 Information Required

Information required to achieve self-reliance is information about contraceptive products and budget needs. This is required to successfully complete procurement of the right contraceptive products in the right amounts and at the right time. Informational inputs required to produce contraceptive forecasts and budget estimates are (1) information about recent program distributions of contraceptives, including trends; (2) strategic program factors that would influence future distribution trends; and (3) suppliers' wholesale prices for contraceptives. Up-to-date information on contraceptive stock levels is also required to ensure that procurement processes are initiated with adequate lead-time to prevent supply interruptions at health care facilities. Before the start of the phase-out period, analyses of contraceptive supply needs were completed by outside consultants with little involvement by MOH technical experts. The start of the contraceptive phase-out period marked the need for information about public sector budget implications of the phase-out; however, initially this analysis too was conducted by outside consultants. The analysis was conducted in 1995 as the GD MCH/FP was preparing its budget request for Turkey's 1996 fiscal year.[12] A self-reliant program would require that the capacity to generate this information exist within the MOH.

B.2 Market Structure and Client Characteristics

Understanding the demand for market structure and client characteristic information was and remains essential. In 1997, as policymakers began to consider adding a targeting component to the self-reliance strategy, they also began to seek information about the family planning market structure and client population characteristics. A market segmentation analysis provided that information, which was used to identify population groups considered most in need of subsidized contraceptive products. For example, information about SSK family planning users served at MOH health care facilities revealed that not only are these clients the largest portion of its client population (37 percent). They are also on average the most costly to serve because SSK users are disproportionately condom users, the most expensive method in terms of commodity costs. This information played an important role in reshaping attitudes about the responsibility of financing MOH's contraceptive supply needs and about the acceptability of targeting those supplies to specifically designated groups.

[12] The GOT follows a January to December fiscal year. Budget development typically begins in June when each GD prepares its estimated budget requirement for the following year. Planning at USAID for contraceptive deliveries during the phase-out period was based on the U.S. Government's October to September fiscal year. This difference required forward planning and analytic adjustments early in the first two phase-out years, as there was confusion about whether the phase-out period (1995–2000) represented a plan that coincided with the U.S. budget cycle (i.e., the year in which USAID would budget its contraceptive purchases for shipment to Turkey) or Turkey's budget cycle (i.e., the year for which "program need" would be defined).

Information about clients' ability and willingness to pay was required to support consideration of targeting strategies. One general strategy to reduce public subsidies to clients willing and able to pay commercial prices for services is to encourage clients away from public services. However, there is an aversion to this in Turkey. Instead, policymakers prefer to consider strategies to encourage better-off consumers to contribute to the cost of contraceptive products within the public system. Two factors explain this policy preference.

First, there is an underlying belief in Turkey that health services are a fundamental right of every citizen. Furthermore, there is a greatly held belief that all citizens have the right to expect the public sector to provide all health services without question of cost or ability to pay. Policymakers frequently cite Turkish law to support these beliefs. However, after some legal analysis and policy dialogue, such citations have become less common. Second, as many case study respondents explained, family planning program experts strongly believe that demand for family planning services among modern method users is fragile among Turkish consumers. They explained that program managers are unwilling to risk erosion of modern contraceptive prevalence and other associated women's and children's health indicators by restricting access to public family planning services.

Willingness-to-pay analyses, therefore, focused on what costs family planning clients at public health care facilities would be willing to bear. These analyses were conducted within the context of a targeting strategy, whereby non-poor family planning clients were asked to donate part or all of the cost of contraceptives supplied to them. It is envisioned that this strategy will be administered by the HSAF, since it already collects donations at nearly all MOH health care facilities nationwide and for nearly every health service. The HSAF assessment found a widely distributed ability to pay donations. Although important organizational and operational issues need to be investigated further and a field trial (scheduled for 2000) before such a strategy could wisely be implemented nationally, the GD MCH/FP and HSAF support taking this next step toward mobilizing resources from clients.

B.3 Further Information Needs

New needs for information arise over time, and alertness is essential to meet those needs. As should be the case, stakeholders in Turkey have driven the demand for information in some planning and decision-making processes. Examples include development of the National Strategy for Women's Health and Family Planning and the GD MCH/FP's policy dialogue with the Minister of Health to obtain access to the Minister's Special Fund. However, demand for other information had to be generated outside of government planning and policymaking processes. Examples include market structure information and feasibility assessments of various components to targeting strategies. As the self-reliance strategy is implemented nationally, information to assess operations will be required. It is important that demand for this information come from within the national program once technical assistance from donors is terminated. Similarly, there will be a need for routine information, such as annual contraceptive commodity forecasts and budget requirement estimates. Establishing conditions whereby these analyses are called for and conducted independently of external technical assistance is important to the sustainability of Turkey's self-reliance strategy. A trained, four-person team is now in place to ensure that this information is produced on time in future years.[13]

Dissemination of information is as important as its generation. A number of case study respondents called for greater openness in public sector decision-making processes, citing this as a factor

[13] USAID and its cooperating agencies have conducted training for contraceptive procurement needs throughout the phaseout period. POLICY has supported this training and added a component on budget analysis methods. In spring 1999, POLICY conducted a comprehensive training program for the new four-person self-reliance team at the GD MCH/FP.

that has slowed progress toward defining a sustainable solution to contraceptive phase-out. There have been instances in which public policymakers have been reluctant to "go public" with plans until near the end of the process. Earlier dissemination of information will increase the ability for a wider range of stakeholders to participate in policy development, expand the set of alternatives identified to achieve policy objectives, and ultimately create a more supportive constituency for decisions. This, in turn, will improve prospects for successful policy implementation.

A final challenge is to overcome the tendency to compartmentalize skills and decision-making authority, especially in the area of contraceptive forecasting and budget analysis. The consequence is that when one person leaves a position, a gap is created that is hard to fill. Although that particular problem has now been overcome, it serves as a case in point in Turkey's self-reliance process.

B.4 Vital Issues Related to Technical Capacity

Two additional issues emerged from the case study about technical capacity for analysis. The first issue concerns performance of analytic and technical tasks. Perceptions among case study respondents were that external consultants have led most of the analytic tasks, providing only the results to GD MCH/FP senior staff. Respondents recommended that the GD MCH/FP take more responsibility to conduct needed analyses. Several reasons account for the fact that the GD MCH/FP has not assumed more independent responsibility to date. First, few staff persons have been explicitly designated to conduct these analytic tasks. As noted earlier, beginning in 1996, the GD MCH/FP was urged to appoint a "self-reliance team." While a team was appointed, the two strongest members of that team no longer work at the GD MCH/FP, leaving insufficient technical capacity to conduct these tasks. A strong technical team needs to be reconstituted. At least one case study respondent with intimate knowledge about the GD MCH/FP assessed that existing staff do not possess the appropriate set of analytic skills. An alternative approach is to create a stronger link between the GD MCH/FP and an academic institution where such analytic skills do exist. Second, there is still room for improvement in understanding how information from analyses can or should be used. Many case study respondents cited a tendency among public policymakers in Turkey to solve problems by crisis response rather than planned response based on analytic information. Respondents said that this is not unique to the health sector. Until the power of information to inform good policymaking is more widely accepted, the demand for such analyses—and consequently, the technical skills to conduct them—will remain less than optimal.

The second issue concerns the timing of completing analyses. The shift from the donor's timetable to the domestic timetable for budget planning appears to have been completed only this year. Contraceptive commodity forecasting and budget-requirement estimation need to be completed in time for GD MCH/FP budget planning (June). However, initiation of these analyses has generally been prompted from external technical assistance partners, rather than from within public institutions. Next year will be an important indicator of whether the shift is indeed complete. That the GD MCH/FP found use for this information in policy dialogue and advocacy at the Minister's Office and with senior MOF staff bodes well. Additionally, in its 2000 budget request, the GD MCH/FP's requested the full amount required to achieve contraceptive self-reliance and prospects are good that earmarked funds will be allocated. These recent developments are constructive from creating demand for the information, and they engender demand on a schedule that suits the budget planning cycle.

C. Advocacy

Advocacy efforts to support development of a contraceptive self-reliance strategy can be categorized as internally or externally driven.[14] Both types of advocacy were the most recent components of self-reliance efforts to take hold.[15]

C.1 Internal Advocacy

Internal advocacy is defined here as efforts by GD MCH/FP staff to promote their financing and program support needs to compensate for donor phase-out of contraceptive supplies. Targets of internal advocacy would principally be other MOH GDs, the MOH Minister's Office, and the MOF. Other government agencies would be legitimate targets for internal advocacy efforts to elicit support for components of the self-reliance strategy, such as mobilizing resources from MOH family planning clients.

C.1.1 Initial Reluctance

The early phase-out period was marked by reluctance to engage in internal advocacy. For example, during the first two years of the phase-out, the GD MCH/FP did not include contraceptive budget requirements in their annual budget requests. In the political and administrative environment of that time, senior GD MCH/FP officials described such advocacy steps as politically risky and bureaucratically infeasible. Unwillingness to engage in internal advocacy was no doubt also related to the fact that, as noted above, the phase-out did not begin to have a negative impact on supplies until the third year. These early phase-out years were also characterized by lack of a critical mass of information about the dimensions of demand for MOH family planning services, and the expected consequences of the impending changes. Regardless of the reason for low internal advocacy activity, the effect was that key decision makers, especially at the MOH Minister's Office and the MOF, were not sufficiently aware of the need.

In 1997, the first bold internal advocacy action was taken. Unexpectedly, funding for line item 400 (consumable supplies) was increased by nearly US$500,000. The general director declared that this new money was allocated for contraceptive commodity procurement and instructed that these funds be so spent. Although the amount available was more symbolic than substantive in terms of total need, this act, and the subsequent procurement processes that were initiated, demonstrated that the MOH's need was real. It also provided a concrete mechanism to engage the Minister's Office in dialogue about contraceptive self-reliance, given that the first step in the procurement process is to seek the undersecretary's permission to spend funds. This advocacy action was considered a safer way to inform senior MOH officials about the need. In addition, this action also served as a critical launching pad for subsequent successful internal advocacy efforts.

C.1.2 Effects of Leadership Changes

Leadership changes presented both advocacy challenges and opportunities. In Turkey, ministers of government agencies change often, and it is a challenge to quickly bring each new minister up to speed on pressing issues as self-reliance. Self-reliance advocates competed with advocates of other issues for

[14] The focus of discussion about advocacy in this paper is on internal advocacy. For additional information about external advocacy efforts, refer to the case study of KIDOG.

[15] The pace of advocacy efforts in the contraceptive self-reliance process has not been unreasonable given the context in Turkey, where the concept of advocacy is relatively new. Time was required to nourish an advocacy mindset, both among public officials and among external advocacy groups. Furthermore, KIDOG required a period of organizational development before they were ready to take on an active advocacy campaign for self-reliance.

the minister's support. By the end of 1997 and throughout 1998, senior staff at the GD MCH/FP had become well versed with the increasing mass of analytic information, developing effective skills for communicating this information to the minister and his senior staff. There was also a change in MCH/FP general directors in 1997, and the well-versed senior staff was effective in communicating self-reliance issues to him. This change occurred coincident with the first signs of a diminishing contraceptive stock situation. The general director, a true policy champion, led successful efforts to advocate at the Minister's Office for financial support. The result (Table 2, page 4) was a dramatic increase in the amount of money spent to purchase contraceptives. Although impressive, the amount allocated and spent in 1999 still represents only 50 percent of needed spending.

A change in USAID's phase-out schedule of contraceptive deliveries also motivated increased advocacy action on the part of GD MCH/FP staff. In 1997, USAID was scheduled to ship 60 percent of MOH's estimated need for condom supplies. It announced instead that it would ship 44 percent that year. Moreover, USAID announced that 1997 would be the last year in which it would ship condoms to Turkey, effectively truncating the phasing out of condoms by two years. The impact on condom stocks was dramatic, creating a sense of urgency that had previously not existed. There was a coincident improvement in the GD MCH/FP's acquisition and use of information on stock-level trends and resource needs for contraceptive supplies. More importantly, the GD MCH/FP, backed by messages about potential health consequences of inaction, proactively and effectively sought out opportunities to bring this information to senior MOH officials. Case study respondents were nearly unanimous in their assessment that success in 1998 and 1999 on the resource front is attributable to the general director's strong internal advocacy efforts.

Internal advocacy achievements are seen as among the most important self-reliance successes. Case study respondents, however, also consider these achievements fragile. For example, internal advocacy is credited with unlocking the Minister's Special Fund as a source of financing for contraceptive supplies. However, the fund is not considered reliable for the long-term. The fund is intended to meet emergency needs, while contraceptive supply needs are recurrent. Respondents also said that success has been driven by the fact that recent health ministers have been convinced that family planning services should receive priority attention. Many worry that the next minister may not hold the same opinion. They say that advocacy attention needs to focus now on institutionalizing budget support for contraceptives. To that aim, the GD MCH/FP began to turn its advocacy efforts to MOF officials, a move that is essential for long-term self-reliance. In the past, the GD MCH/FP considered engaging in advocacy efforts aimed at other groups such as parliamentarians, who consider these kinds of activities too risky, and in the end did not undertake such actions. Instead, these were left to the domain of external advocacy organizations.

C.2. External Advocacy

External advocacy is defined here as efforts by NGOs to encourage and support movement toward defining a sustainable contraceptive self-reliance strategy. From the start of self-reliance policy dialogue in Turkey (1995), NGOs have been a mainstay at the policy dialogue table. Most notably, an organization that has played an increasingly important role is KIDOG, which is an umbrella network of NGOs whose interests span a wide range of women's issues. KIDOG was constituted in 1995, and during its first two years focused primarily on institution building. In late 1997, KIDOG took an active role in the self-reliance issue. At that point, it sought information about the parameters of the phase-out, MOH needs, and performance and outcomes of efforts at that point. It then developed a high-profile advocacy campaign designed to bring greater visibility to the need, both to the public and to public officials and political leaders who are more difficult to reach through internal advocacy efforts.

C.2.1 NGO Network Participation

The growing role and influence of KIDOG is widely welcomed. At the national level, awareness of KIDOG and its activities is nearly universal. It is widely recognized as an important new participant in the process of defining a national contraceptive self-reliance strategy. Most respondents were of the opinion that KIDOG has had a positive impact on raising awareness about self-reliance issues, and that it has been effective in raising the priority level of contraceptive self-reliance as a public policy issue. Nearly one-half of the respondents believe that KIDOG's activities had an impact on resource allocation for contraceptives, although the importance of other factors was also acknowledged. For example, KIDOG's audience with the president of Turkey in 1998 is widely credited as an important step in gaining high-level policy support for contraceptive financing. As a result of that meeting, the Minister of Health was directed to allocate funds to purchase the quantity of contraceptives required to meet 1998 program needs. Although this action played a role in securing resources from the Minister's Special Fund, internal advocacy by GD MCH/FP was described as an equally important factor.

There is also widespread support for KIDOG to adopt an even stronger role in the self-reliance policy arena. For example, respondents suggested that KIDOG take steps to increase its visibility. To achieve this, respondents said that KIDOG should consider expanding its membership to new organizations, especially among NGOs outside the Istanbul area. Increased community-focused grassroots activities was also mentioned as a strategy to increase KIDOG's visibility. Respondents also suggested that efforts be made to highlight KIDOG's independence from public agencies and officials.

There is also a sense that KIDOG members have a considerably larger network of high-level government and political contacts than they have heretofore tapped. Respondents urged that KIDOG broaden its target audience to a wider range of government and political organizations. Most respondents agreed that part of the answer to their call for a stronger, more active KIDOG is a matter of time. KIDOG only began to coalesce as a network after the phase-out period began; and for much of the early part of the period, it was engaged in organization building. These respondents suggest that by natural course, KIDOG can be expected to play an increasingly important role in supporting the public sector to put in place a sustainable self-reliant contraceptive supply.

V. CONCLUSION: SELF-RELIANCE IS IN SIGHT

In Turkey, opinion is mixed about how close the MOH is to achieving contraceptive self-reliance. Part of the difference of opinion is attributable to how self-reliance is defined. For those who define self-reliance as the absence of donated contraceptives, Turkey certainly will be self-reliant by 2000, when all contraceptive commodities in the national program are financed without donor resources. The GOT has made great strides in identifying and spending government resources, amounting to almost 50 percent of program needs in 1999. A second group that defines self-reliance as the continuation of the public sector program declares that Turkey has already achieved self-reliance, since despite severely restricted contraceptive donations (for example, Turkey has received no donated condoms since 1997), MOH family planning services have continued at the field level without change and virtually without supply interruptions.[16] Although a third group acknowledges considerable progress toward the self-reliance goal, they state that self-reliance will only be achieved when contraceptive stock levels are at the 15-month cushion of supply. To achieve this within current program parameters, the GOT would have to spend

[16] Stock-outs at the health care facility level have periodically been reported. Investigations into each of these reports, however, revealed that in all but one case, the problem was a logistics problem, not a stock problem. Only once, in early 1999 was the stock-out due to a supply shortage. See section II, part E. for details about this event.

approximately US$5 million per year on a sustained basis. Although the MOH is making steady progress toward this goal, the MOH has not yet achieved it.

Regardless of the definition of self-reliance used, accomplishments toward that goal are undisputed and include the following:

- ***Resources*** **-** Turkey has progressed from spending no money on contraceptives in 1996 to spending $645,000 in 1997 and more than $1.5 million in 1998. The amount spent in 1998 represents 40 percent of what was needed to achieve its financing goals that year. To date, the MOH has spent $1.1 million and is in the process of completing another purchase worth $700,000. The total is nearly one-half its 1999 need. More importantly, the MOF has verbally committed to fully funding MOH's year 2000 needs for contraceptive procurement by using earmarked, on-budget resources. The MOF has further committed to on-budget financing of contraceptives for a limited (though undefined) period until the other elements of the strategy (targeting and cost recovery) are in place.

- ***Procurement*** **-** Since 1997, the MOH has successfully completed several large contraceptive procurements. Moreover, recognizing the value of initiating procurement early in the program year, MOH completed its largest procurement early in 1999. The MOH's experience with these procurements has also shown the risks of assuming short timeframe requirements for procurement; planning has commensurately been adjusted.[17]

- ***Participation*** **-** Many respondents described the strong communication channel developed between the GD MCH/FP and commercial pharmaceutical firms as among the most impressive changes occurring during the phase-out period. Representatives of these firms have had a consistent presence at most self-reliance policy dialogue forums, and a great deal of communication presently exists outside of those formal settings. As evidence of the evolving healthy public-private partnership, one respondent told of an agreement whereby a pharmaceutical firm agreed to assist the GD MCH/FP with financing for a family planning education campaign. As the MOH has become more comfortable having these representatives at the policy dialogue table, it has also become more open to participation from other stakeholder groups. Case study respondents also pointed out that inclusion of other GDs and government agencies in self-reliance policy dialogue and planning is a welcome departure from the standard, more closed policymaking and planning mechanisms that prevail in Turkey's public sector.

- ***NGOs*** **-** The success of NGOs deserves special attention. In particular, KIDOG has provided a tremendous boost to self-reliance advocacy. The network has developed a highly supportive relationship with the GD MCH/FP, successfully reaching high administrative and political levels to increase awareness and lobby for action. While case study respondents had a number of suggestions to increase KIDOG's effectiveness further (see previous section), the value of KIDOG's contribution is without question.

- ***Public Sector Subsidies and Targeting*** **-** A centerpiece of self-reliance policy discussions is presently the GD MCH/FP's intention to employ a targeting approach to achieve contraceptive self-reliance. A guiding principal of this approach is that the MOH will maintain its long-standing commitment to serve all who seek family planning services; no clients will be turned away. Instead, targeting is intended to raise the resources needed to keep MOH's service delivery system well supplied.

[17] This statement refers to a situation described earlier in this report, in which MOH had assumed a short time lag between signing a bid for condoms and receiving the supplies. Supplies took longer than expected and warehouses were caught short and unable to fully supply provinces using the "Top-up" logistics supply system. Rather than using the minimum expected time lag, a safer average time lag assumption is now used for planning.

According to the plan favored by the GD MCH/FP, poor clients will continue to receive their contraceptive method for free. Non-poor clients will be asked to contribute to the cost of contraceptives supplied to them by making a donation to the HSAF.[18]

Some case study respondents said they see targeting as the lynchpin in the MOH's self-reliance strategy. They pointed to what they perceive as the inescapable reality that, in the long-term, public sector budget resources will not cover all contraceptive supply costs of the current program. In the absence of an alternative source of funds, some clients would inevitably loose access to services; thus, a targeting approach is the only strategy to protect the poor who would have less access to the commercial market. Respondents also described challenges that will need to be dealt with to successfully implement a targeting strategy. The most commonly named challenge was the need to devise a sound management system. In addition, resistance to the concept of targeting remains in some quarters. Continued efforts are needed to build a broader foundation of support, especially among those who feel targeting undermines the prevailing notion of health care as a right and that it contradicts the public sector's responsibility to provide services to all. As chief implementers of the targeting component, support from local health administrators, managers, and providers will be crucial. Efforts to enlist that support need to begin.

In short, although the rationale for targeting is clear, some leaders still hope that policymakers can be convinced of allocating sufficient resources to maintain the public sector's family planning program in its current untargeted form. Within the GD MCH/FP, however, most leaders now agree that targeting is likely to be an important dimension of a self-reliant public sector family planning program, and they actively support it.

In summary, most respondents agreed that impressive progress has been made towards defining a workable self-reliance strategy. Consensus on the basic components of a national self-reliance strategy has been reached. For the short-term, public financing for contraceptives will be mobilized. Simultaneously, alternative financing strategies are being devised and put in place to ensure longer-term public financing for clients too poor to contribute to the cost of their contraceptives. Resource mobilization will be derived not only from the GOT budget but also from clients' donations to the HSAF. Case study respondents suggested additional steps to facilitate the final stages of developing and implementing the self-reliance strategy. Organized representation of private practice physicians was mentioned as another desired input. Respondents also suggested that efforts be continued to increase awareness about contraceptive self-reliance needs among decision makers in social insurance organizations. Respondents said they expect strong support once these leaders are fully aware and involved in the policy dialogue and planning process. Continued active involvement of senior leaders rather than their designated mid-level staff will also contribute to expeditiously carrying out the final steps in achieving self-reliance.

The question for Turkey's family planning program is not whether it will survive, but what kind of program will emerge in the aftermath of the phase-out and what configuration of resources will be used to finance that program. Most case study respondents agreed that much has been accomplished since the phase-out began in 1995. Some respondents stated that a longer technical assistance lead-time might have produced self-reliance results earlier. This position assumes that progress has been a function primarily of time and technical assistance rather than locally perceived program need. An alternate view is that the phase-out was designed to minimize program disruption, and while it succeeded in doing so, it removed much of the incentive in the early years for the GOT to act. In addition, the sense of urgency about contraceptive supplies certainly increased as the phase-out period proceeded. The question raised is

[18] The HSAF already collects donations for health services received at nearly all MOH health care facilities nationwide.

whether this sense of urgency could have been created earlier without jeopardizing the program, thereby increasing incentives to take stronger action earlier. In a policy environment said to be predisposed to reacting to issues only when the issues have entered a crisis phase, perhaps a phase-out plan designed to create this sense of urgency earlier would be as effective in providing a longer technical assistance lead time.

Whichever perspective, the goal of self-reliance is now in sight. Continued, perhaps even intensified, effort and vigilance will be required to take the final steps, and technical assistance will play a useful role in supporting such efforts. The most useful elements to focus on now are putting a rational targeting strategy in place that includes a cost recovery mechanism; drawing local health administrators, managers, and providers into dialogue and planning; and maintaining the awareness, attention, and support of senior, influential decision makers.

One case study respondent said, "The GD MCH/FP has learned to fight for its needs; this has made all the difference in the pace of progress towards self-reliance." In the new environment at the GD MCH/FP and with this "fighting spirit" and increasingly participatory approach to policy dialogue and planning, there is reason to be optimistic about the prospects for Turkey's family planning program.

APPENDIX A

BIBLIOGRAPHY

Commodity Procurement Policy Workshop: Final Report. 1996. The POLICY Project.

Forecast of Public Sector Budget Requirements for Contraceptive Commodities in Turkey: 1995–1999. 1995. The POLICY Project.

Forecast of Public Sector Budget Requirements for Contraceptive Commodities (June 1996 Update). 1996. The POLICY Project.

Forecast of Public Sector Budget Requirements for Contraceptive Commodities (June 1997 Update). 1997. The POLICY Project.

Forecast of Public Sector Budget Requirements for Contraceptive Commodities in Turkey: 1998–2000. 1998. The POLICY Project.

Forecast of Public Sector Budget Requirements for Contraceptive Commodities:1998–2000 (June 1999 Update). 1999. The POLICY Project.

Health and Social Aid Foundation Assessment Report. 1999. The POLICY Project.

Leader Service Providers in FP Private Sector in Turkey. 1997. The POLICY Project.

Public/Private Partnership Workshop Report. 1997. The POLICY Project.

Segmentation in Turkey's Family Planning Market. 1997. The POLICY Project.

Targeting Subsidized Contraceptive Commodities: A Brief. 1999. The POLICY Project.

Turkey Strategy, 1996–1998, and Workplan March 1–December 31, 1996. 1996. The POLICY Project.

Turkey Workplan Update, July 1998–September 1999. 1999. The POLICY Project.

APPENDIX B

CASE STUDY INTERVIEW RESPONDENTS

Dr. Ibrahim Açikalin, GD MCH/FP, Ministry of Health
Dr. Ahmet Afsar, Ministry of Health
Dr. Ayse Akin, Haceteppe University
Dr. Seçkin Atabas, Health Project, Ministry of Health
Dr. Ugur Aytaç, GD MCH/FP, Ministry of Health
Dr. Mehmet Ali Biliker, GD MCH/FP, Ministry of Health
Dr. Çigdem Bumin, AVSC
Dr. Levent Çagatay, AVSC
Dr. Volkan Çakir, FUTURES
Dr. Tahsin Ecer, Curative Care GD, Ministry of Health
Oya Eksen, KIDOG
Melek Erman, European Union
Seyda Ertugrul, Eczacibasi
Murat Firat, KIDOG
Dr. Muzaffer Keçeciler, Deputy Undersecretary, Ministry of Health
Dilara Kehale, KIDOG
Dr. Mehmet Kontas, State Planning Organization
Dr. Mehmet Rifat Köse, General Director, MCH/FP, Ministry of Health
Nurcan Muftuoglu , KIDOG
Dr. Behire Özek, JHPIEGO
Dr. Selale Özmen, Private practice physician
Dr. Ahmet Ozirmak, UNFPA
Dr. Pinar Senlet, Population Advisor, USAID
Dr. Ersin Topçuoglu, MSH
Dr. Sunday Uner, Haceteppe University
Abdurrahman Vargun, Ministry of Finance
Dr. Gökhan Yildirimkaya, Social Security Organization (SSK)
Ela Yazici, European Union
Sinasi Yoruk, Schering